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Written testimony of Matthew V. Barrett, Executive Vice President of the Connecticut Association of Health Care Facilities (CAHCF), and Mike Mosier, Chief Financial Officer, Athena Health Care in Support of S.B. No. 899 AAC VOLUNTARY BED REDUCTIONS AT NURSING HOME FACILITIES

Good afternoon Senator Moore, Representative Abercrombie and to the members of the Human Services Committee. My name is Matthew V. Barrett, Executive Vice President of the Connecticut Association of Health Care Facilities (CAHCF), our state's one hundred and sixty (160) member trade association of skilled nursing facilities and rehabilitation centers (SNFs). Thank you for this opportunity to offer testimony this afternoon in support of S.B. 899 AAC VOLUNTARY BED REDUCTIONS AT NURSING HOME FACILITIES. I am pleased to be joined this afternoon by Mike Mosier, the Chief Financial Officer at Athena Health Care. Mike's participation in today's testimony is very important because Athena has considerable experience with the voluntary bed reduction models being advance in SB 899 as they are based on models operated in Rhode Island and Massachusetts where Athena also has SNFs in addition to their corporate home and significant SNF presence in Connecticut.

S.B. 899 offers Connecticut a reasoned and planned approach to the voluntary reduction of licensed SNF beds. Efforts to move Medicaid recipients out of more costly SNF settings and into more affordable home and community based environments in such programs as the state's hallmark Money Follows the Person (MFP) have been very challenged to meet their expressed goals. For example, the MFP Demonstration Grant was to transition some 5200 SNF residents to home and community based settings by 2016. In the MFP program's Quarter 4, 2014 report, 2408 demonstration consumers transitioned. Last week, DSS reported that they anticipated 700 new transitions in 2015 and 850 in 2016 due to a recent reorganization of the MFP program. These ambitious new DSS transition estimates represent a considerable increase from the current transition experience in the program. At once, the remaining SNF population is anticipated to have higher acuity and more complex needs than so far experienced in the MFP program.

Among other factors, MFP's success has been frustrated by an excess supply of licensed nursing facility beds. However, nursing facilities have been reluctant to de-licensed beds. The reluctance stems from the justifiable notion that if facilities reduce their licensed capacity, the reduction would cause a permanent reduction in the facilities' value. However, CAHCF wants to be very clear. This is not an argument against the value and importance of the MFP program. This is an argument for the need of a responsible voluntary bed reduction program.

In general, SB 899 would allow a nursing facility to, on a temporary basis, voluntary de-license a sufficient number of beds, including occupied beds, to cause the facility to achieve a higher occupancy rate. Residents in de-licensed occupied beds would, if they chose, transition to another nursing facility within a 15 mile radius or to MFP.

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Attached to this testimony is a detailed example of how the models would work for a typical 120 bed SNF, including information on the Rhode Island and Massachusetts' models. In summary, a nursing facility with a capacity of 120 beds has maintained an occupancy rate of 90 percent for many months. In other words, of its 120 beds only 108 are occupied. To increase the facility's occupancy rate, the facility could reduce its capacity to 109 beds (108/.99). However, under this plan the facility must also de-license occupied beds and give the affected residents a choice to either relocate to another facility or be cared for at home under MFP.

The facility's physical plant configuration suggests that it could efficiently operate at a capacity of 90 beds. Under such a scenario the facility would de-license a complete wing of 30 beds (120-90).

The facility's new capacity of 90 beds would necessitate the relocation of eighteen (18) residents (108-90). It is assumed that, given the choice, approximately one in four residents would qualify for *and* be willing to receive their care in a community setting. Accordingly, thirteen (13) of the eighteen affected residents in our example would relocate to another nursing facility and five (5) would receive care under MFP.

The net cost to the state for care in a nursing facility is approximately $2,650 per month, whereas the net cost to the state under MFP is only $963. Therefore, with regard to the residents in our example who elect to be care for under MFP, the state would realize an annual savings of $101,220 ($2,650-$963*12*5).

Information published by DSS indicates that there are 200 nursing facilities in the state that are operating at less than 99 percent of capacity. If each of those 200 facilities reduced their capacity by an amount to cause at least five residents to opt for MFP, the state would realize an annual savings of $20.2 million ($101,220*200), and 1,000 (5*200) individuals would realize the benefits of MFP.

While not every nursing facility would agree to reduce its capacity, many others might agree to a reduction in an amount that could cause more than five residents per facility to opt for MFP. Moreover, with the anticipated change to an acuity-based reimbursement system, the incentive to reduce capacity would be even greater and the savings potential would increase as well.

The public policy reasons for advancing a long term care rebalancing strategy are well known. There are 1 million baby boomers in Connecticut. There are 600,000 residents in Connecticut over the age of 60. Connecticut's aging population is among the oldest in the Nation, with over 160,000 Connecticut citizens over the age of 80 according to a December 2012 report issued by the U.S. Census Bureau. Much is being asked of our nursing facilities today, and more will be asked in the future given the dramatic aging of our population. As the state continues in the direction of long term care rebalancing

and rightsizing, these changes will mean that the acuity and numbers of nursing facility residents will continue to rise measurably as our population ages, even as more residents choose home and community based environments to receive their care.

A responsible voluntary SNF bed reduction program can help advance these goals.

Thank you and I would be happy to answer any questions you may have.

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